Guide to Client and Data System Report and Statewide Summary

This report presents data on clients and services provided by local publicly funded mental health programs in California from Fiscal Years (FY) 1990-1991 through 1997-1998. The report is based on reporting to the Client Data System (CDS) by all county mental health programs and two city mental health programs, Berkeley City in Alameda County and Tri-City, composed of Pomona, Claremont, and La Verne in Los Angeles County. The CDS reporting started in FY 1984-1985 and previous reports have been published through FY 1989-1990. This report covers the next eight years of reporting until CDS was replaced in FY 1998-1999 by the Client and Service Information (CSI) System. Although information is now several years old, producing this report will help complete an historical picture of trends in the California public mental health system.

This report will concentrate on two types of data derived from the CDS reporting, specifically unduplicated clients and number of admissions and average length of stay (ALOS) for 24 hour services.

DEFINITIONS OF TERMS AND TECHNICAL NOTES

Unduplicated Clients

The CDS required reporting of clients and services at the individual person level for each type of service and provider in which the clients received services. Some counties had a unique countywide client number used to identify the client. Other counties did not have unique countywide client numbers. For counties without a unique countywide client number the client's date of birth, first and last initial, and gender are used as a unique identifier. For those counties with a unique client number the clients were unduplicated using both the unique client number and the generated unique identifier. This resulted in a five-percent difference between the two counts, either lower or higher than the unique client number count.

Penetration Rate

A penetration rate or utilization rate indicates the percentage of people who receive services out of a total number of people. For this report the penetration rate is calculated by dividing the number of unduplicated clients by the general population and multiplying by 100. This rate is calculated for FYs 1990-1991 and 1997-1998. This is the percent of the California population who received local public mental health services.

Number of Admissions and Average Length of Stay (ALOS)

Some of the facilities included in this report changed definitions or type of service over the eight-year period. Below are the type of facilities included in the categories of Institutional Inpatient, Institutional Non-Inpatient, and Residential.

Institutional Inpatient includes Hospitals and Psychiatric Health Facilities (PHF).

Institutional Non-Inpatient includes Skilled Nursing Facilities (SNF) Intensive, SNF-Institutes for Mental Disease (IMD), and Mental Health Rehabilitation Centers (MHRC).

Residential includes Crisis Residential, Transitional Residential, Adult Crisis Residential, Adult Residential, and Other Residential.

The number of admissions is calculated using the admission date. The average length of stay (ALOS) is calculated by subtracting the admission date from the discharge date.

Policy and System Changes Affecting Data in the Report

Phase I Consolidation. This is a consolidation of Mental Health Inpatient services, commonly known as Inpatient Consolidation (IPC), where the counties became responsible for authorizing treatment for Medi-Cal services in Non Short-Doyle/Medi-Cal (SD/MC) hospitals, also referred to as Medi-Cal Fee-For-Service Mental Health Inpatient. This consolidation occurred January 1, 1995. Although these services are not reported to the CDS, the facilities that are reported showed a decrease in average length of stay (ALOS) similar to the decrease that occurred with the IPC data.

Phase II Consolidation. During Fiscal Year 1997-1998 counties phased in the consolidation of the Fee-For-Service Professional Services into the County Mental Health Plans. All Counties finished the consolidation by July 1998. Some increases in clients and services during this Fiscal Year are due to this consolidation.

Realignment. Some of the changes in admissions between fiscal years are due to funding changes that were part of realignment.

1. In FY 1991-1992 the State Hospital resources used by counties for services to persons admitted under voluntary and involuntary civil commitment laws were realigned to the counties. This provided counties greater flexibility to purchase state hospital services or use the funds to purchase other services. Many of the counties chose to move their clients from state hospitals to local Skilled Nursing Facilities (SNF). The CDS data shows an increase in SNF admissions for this fiscal year.
2. In FY 1992-1993 the counties were allocated the resources for the services that were provided in SNFs that had been determined to be Institutes for Mental Disease (IMD). With the county responsibility for payment of these services, the counties were to report these services to CDS, and there is an increase in admissions for this fiscal year.
3. Department of Mental Health staff compared the services reported in the CDS to those reported in the County Cost Reports. In general, there was an underreporting to CDS and the largest service category with underreporting was for SNF-IMD facilities. These comparisons over time brought this underreporting to the awareness of the counties and reporting to CDS became more complete over time.

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment Program). EPSDT is a federally mandated Medicaid program. Implementation of this program began in FY 1995-1996. The large increase in the number of clients receiving services in age groups 0 through 20 during this report period is mostly due to EPSDT implementation.

Some changes across the years at a statewide level and within counties may be due to the occurrence of reporting problems, solving reporting problems, and/or changing of automated systems. Included with the county tables are CDS production reports S4.0. The S4.0 reports show the monthly unduplicated client counts for each county for the eight fiscal years.

These policy changes should be taken into account when analyzing the data.

Data Tables

The tables analyzed in this summary refer to statewide data; there are also detailed tables by region and county.

1. Age. The age groups reported in the tables are based on calculating the age as of January 1 of the fiscal year.

2. Diagnostic Groups. The Diagnostic and Statistical Manual of Mental Disorders (DSM) changed versions during this time period from the DSM-III-R to the DSM-IV. The diagnostic groupings are based on the DSM-IV categories. If more than one diagnosis was reported during the year, the most serious diagnosis was chosen for the tables. Diagnoses are grouped into eight diagnostic categories: Attention Deficit-Hyperactive Disorder (ADHD) and Conduct Disorders, Schizophrenia and Other Psychotic Disorders, Depressive Disorders, Bipolar Disorders, Anxiety Disorders, Adjustment Disorders, Other Mental Health (MH) Disorders, and Deferred/Missing.

3. Other Demographic Data. Other demographic characteristics are based on the values reported on the most recent admission record. There were some service records with no matching admission record. This occurred more often during the transition from CDS to CSI. Counties were given a two-year time period to correct these records. After the two-year period passed, the Department of Mental Health staff generated admission records for these clients so that the service records could be accepted into the system. The generated admission records contained unknown values in the demographic data fields and can be seen in the tables with an increase in unknown values for the last two fiscal years, especially for the 1997-1998 FY.

California's Five Mental Health Regions

Bay Area Region (13): Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma counties and the Berkeley City program.

Central Region (19): Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, and Yuba counties.

Los Angeles Region (2): Los Angeles County and the Tri-City program (Claremont, La Verne, and Pomona).

Southern Region (9): Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura counties.

Superior Region (17): Butte, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity counties.

STATEWIDE SUMMARY

Unduplicated Clients

Table 1A shows the number of unduplicated clients by diagnosis, race/ethnicity, gender, and age group, for FY 1990-1991 through 1997-1998. Table 2B is in the same format but shows the percent distribution of clients by the demographic variables. Following are the highlights from these tables.

Total. The total number of unduplicated clients increased from 320,704 in FY 1990-1991 to 390,695 in FY 1997-1998. This is an increase of 21.8 percent while the statewide population increased only 10.1 percent.

Diagnostic Groups. The number of clients in all diagnostic groups increased with the exception of adjustment disorders in which there was a 21.5 percent decrease. In FY 1990-1991 the four diagnostic groups with the largest percent of clients were schizophrenia and other psychotic disorders at 26.4 percent, depressive disorders at 22.6 percent, adjustment disorder at 13.69 percent, and other mental health disorders at 12.75 percent. In FY 1997-1998 the four diagnostic groups with the largest percent were ADHD and conduct disorders at 11.14 percent, schizophrenia and other psychotic disorders at 23.85 percent, depressive disorders at 27.07 percent, and other mental health disorders at 11.58 percent.

Race/Ethnicity
The absolute number of clients in all race/ethnicity groups increased over the time period. The percent increase in number of clients who were White was 2.7 percent, Hispanic 34.2 percent, Black 22.1 percent, and Asian/Pacific Islander 43.8 percent. The White race/ethnicity group as a percent of the total clients declined while the Hispanic and Asian/Pacific Islander increased during the same time period. The percent of Black race/ethnicity group remained about the same.

Gender. The number of both male and female clients has increased. Female clients continue to be about the same percent of the clients through all eight years, while the percent of male clients has declined. This decline may be due to the increase in the number of clients with an unknown or missing gender code.

Age Groups. There was an increase in the number of unduplicated clients for all age groups except the age groups 21-29 and 65+. The decrease of 7.4 percent in the 21-29 age group can partially be attributed to the 3.6 percent decrease in the general population for this age group. The 65+ age group declined about 7.6 percent in FY 1993-1994. For the entire time period, the number of clients aged 65+ declined 2.0 percent while the general population increased 13.2 percent. As a percent of total clients, the largest changes were increases in clients age 0-17 and 40-59, while the largest decrease was in the percent of clients age 21-39.

While the diagnostic data was located on the service record, the demographic data was located on the admission record. The increase in the number of other or unknown values in the demographic data was due to missing admission records.

Tables 2A through 2D are in the same format as Tables 1A and 1B but show separate tables by gender. Following are highlights from these tables.

- Diagnostic Groups. In FY 1997-1998, the four most common diagnostic groups for females were Schizophrenia and Other Psychotic Disorders (20.7%), Depressive Disorder (35.3%), Adjustment Disorder (9.3%), and Other Mental Health Disorders (9.2%). For male clients, the four most common diagnostic groups were ADHD and Conduct Disorders (16.1%), Schizophrenia and Other Psychotic Disorders (27.2%), Depressive Disorders (19.1%), and Other Mental Health Disorders (13.8%).

- Race/Ethnicity Groups. There is very little difference in the percent of the Race/Ethnic Groups by gender.

- Age Groups. Males have a higher percent of clients in the age groups 0-20 than females. Males and females have about an equal percent of clients in the 21-39 age group. Females have a higher percent of clients in the age group 40-65+ than the males.

Tables 3A through 3J are in the same format as Tables 1A and 1B, but show separate tables by race/ethnicity.

- Diagnostic Groups. The three most common diagnostic groups for each Race/Ethnicity are:
  - White: Schizophrenia and Other Psychotic Disorders (23.3%), Depressive Disorders (27.3%), and Other Mental Health Disorders (13.0%).
  - Hispanic: ADHD and Conduct Disorders (15.7%), Schizophrenia and Other Psychotic Disorders (19.4%), and Depressive Disorders (27.5%).
  - Black, ADHD and Conduct Disorders (15.0%), Schizophrenia and Other Psychotic Disorders (29.7%), and Depressive Disorders (33.5%).
  - Asian/Pacific Islander, Schizophrenia and Other Psychotic Disorders (29.7%), Depressive Disorders (33.5%), and Anxiety Disorders (7.9%).

- Gender. The White, Hispanic, and Black Race/Ethnicity groups have a higher percent of males, while the Asian/Pacific Islander Race/Ethnicity group has a higher percent of females.

- Age Groups. The Hispanic and Black Race/Ethnicity Groups have a higher percent of clients age 0-20 than the White and Asian/Pacific Islander Race/Ethnicity Groups, 44.3 percent and 33.7 percent versus 25.9 percent and 21.0 percent.

Tables 4A through 4F show the number and percent of clients by age group within diagnostic groups for FY 1990-1991 through 1997-1998.

- ADHD and Other Conduct Disorders are mostly in the 0-20 age group, as would be expected. The 0-20 age group represents 97.6 percent of the clients with these diagnoses.
- Schizophrenia and Other Psychotic Disorders and Bipolar Disorders occur mostly in the 21-59 age groups. This represents 86 percent of the clients with these diagnoses.
- Depressive Disorders are a little more evenly distributed with the 0-20 age groups at 24.0 percent, 21-39 age group at 32.7 percent, and 40-59 age group at 35.3 percent.
- Anxiety Disorders are mostly in the 0-20 age groups at 40.4 percent followed by the 21-39 age group at 29.0 percent and the 40-59 age group at 25.4 percent.
- The Adjustment Disorders diagnostic group has a similar pattern as the Anxiety Disorders diagnostic group where the 0-20 age groups have the highest percent at 49.0 percent, followed by the 21-39 age group at 32.0 percent, and 40-59 age group at 15.1 percent.

Penetration Rate

The penetration rate is a measure of the number of persons receiving mental health services out of a general population. It shows whether the number of clients served is keeping pace with population growth or decline. The number of clients served is influenced by policy changes and this is also reflected in the penetration rate. The total penetration rate increased from 1.07 percent to 1.19 percent from FY 1990-1991 to 1997-1998. The percent change for the unduplicated clients, during the same time period, is 21.8 while the percent change for the general population is 10.1. All race/ethnic groups and age groups have an increase in penetration rate, except for age groups 21-39 and 65+. The highest penetration rate is the Black Race/Ethnic group at 2.66 and the 13-17 age group at 2.33. With the implementation of EPSDT in FY 1994-1995 you would expect to see a higher penetration rate for the children and youth age groups then the other age groups.

Service Utilization

The following two tables focus on specific aspects of service utilization about which there are frequent inquiries.

Table A shows the number of clients with only one inpatient admission or only one non-inpatient service. Clients who do not continue in service may do so for a number of reasons, such as, they don't meet medical necessity, they don't have a mental health problem, they aren't eligible for services, they choose not to receive services, or they are not able to access services easily. To determine to what extent this occurs, those clients who had either only one inpatient admission or only one non-inpatient service were counted and the percent of these clients to the total clients was calculated. The number of clients meeting these criteria peaked in FY 1993-1994 and declined steadily through FY 1997-1998. The percent these clients represented of the total clients followed the same pattern beginning with 17.91 percent, peaking at 18.65 percent in FY 1993-1994, and steadily declining to 14.09 percent in FY 1997-1998.

Table A
Number of Clients With Only One Non-24 Hour Service
or One Inpatient Admission
and Percent of Total Clients
By Fiscal Year

	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998
Clients	57,430	57,210	59,440	63,671	62,491	55,485	55,589	55,053
Percent	17.91	17.30	17.77	18.65	18.00	16.24	15.30	14.09

Table B shows the number of youth who received mental health services provided in accordance with an Individualized Education Program (IEP). Youth who are in Special Education may require mental health services in order to participate in school. When that is specified in the IEP, county mental health programs must provide the services. The number of children receiving IEP mental health services increased during the time period from a low of 12,366 in FY 1990-1991 to a high of 21,115 in FY 1997-1998. The youth who received IEP mental health services as a percent of total youth aged 5-20 increased through FY 1993-1994 and started to decline in FY 1994-1995. Part of the decline in percent of total clients age 5-20 may be due to the increase in Medi-Cal eligible children receiving mental health services through the EPSDT program.

Table B
Number of Clients Receiving IEP Services
and Percent of Total Clients
By Fiscal Year

	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998
Clients	12,366	13,861	14,784	17,017	17,615	18,233	19,486	21,115
Percent	16.54	17.57	18.45	20.96	20.56	20.75	19.33	18.34

Number of Admissions and Average Length of Stay

A department goal is for clients to live in the least restrictive environment. One of the ways to monitor the goal is to look at the number of admissions and the average length of stay over time. This section looks at three different types of restrictive environments from the most restrictive to the least restrictive, that is, from Institutional–Inpatient, Institutional Non-Inpatient, and Residential. The data are arranged by Diagnosis, Race/Ethnicity, Gender, and Age, for the FYs 1990-1991 through 1997-1998.

Tables 6A and 6B display the number of admissions and average length of stay for Institutional Inpatient clients.

- Total. The number of admissions increased from 33,339 admissions in FY 1990-1991 to 38,178 admissions in FY 1997-1998. The number of admissions as a percent of the total number of clients declined from 10.4 percent in FY 1990-1991 to 9.8 percent in FY 1997-1998. While the number of admissions increased, the average length of stay decreased from 10.8 days in FY 1990-1991 to 8.8 days in FY 1997-1998.

- Diagnosis. All average lengths of stay decreased for every diagnostic group except the Deferred/Missing. The most significant decrease is in the ADHD and Other Conduct Disorders from an average of 25.7 days to an average of 13.8 days. The number of admissions for this diagnostic group also declined from 527 to 425. The number of admissions declined in all diagnostic groups except the following, Schizophrenia and Other Psychotic Disorders, Depressive Disorders, and Bipolar Disorders.

- Race/Ethnicity. The average length of stay for all Race/Ethnicity Groups decreased. The number of admissions for all Race/Ethnicity Groups increased, except for the White Race/Ethnicity Group. The differences in Race/Ethnicity should be compared within Regions as most of the non-White general population and clients reside in Los Angeles County and the Bay Area. This table is located with the regional and county tables.

- Age Group. The average length of stay decreased for all age groups, with the greatest decrease in the age groups 5-9 and 10-12, from 41.5 to 16.7 days and 26.7 to 17.1 days respectively. The age groups 5-12 have the longest lengths of stay.

Tables 7A and 7B display the number of admissions and average length of stay for Institutional Non-Inpatient clients.

- Total. The number of admissions increased during the eight-year period. The increases are due to many policy changes occurring during the earlier fiscal years. Please see the introduction on policy changes affecting the data on page 2. The average length of stay increased with the policy changes and stayed within 71 to 79 days for the last five fiscal years of this report. Institutional Non-Inpatient Facilities are long-term facilities while the Institutional Inpatient facilities are more acute short-term facilities.

- Diagnosis. Most lengths of stay by diagnosis are within the range of 71-79 days, with the following exceptions: Schizophrenia and Other Psychotic Disorders have a longer length of stay, and Depressive Disorders, Adjustment Disorders, and Other Mental Health Disorders have a shorter length of stay, with Adjustment Disorder having the shortest at around 7 days.

- Race/Ethnicity. The White and Black Race/Ethnicity Groups have the longest length of stay, with the Hispanic Race/Ethnicity Group having the shortest length of stay.

- Gender. There is very little difference between the length of stay for females and males.

- Age Group. Length of stay increased with age with the age group 65+ having the longest length of stay at over 100 days and the 40-64 age groups having around 90 days.

Tables 8A and 8B display the number of admissions and average length of stay for Residential clients.

- Total. The number of admissions averaged around 8,000-9,000 during the first seven years. The last fiscal year shows a decline to 7,731 admissions. This is due to reporting errors and not an actual decrease in admissions. During the change from CDS reporting to CSI reporting some of the residential facilities were not reported to CDS. The average length of stay has been steady at around 29 to 35 days. This type of service is not as short-term as the Institutional Inpatient services, but is shorter than the Institutional Non-Inpatient services.

- Diagnosis. Most of the Admissions have a diagnosis of Schizophrenia and Other Psychotic Disorders, Depressive disorders, and Bipolar Disorders and have an average length of stay between 26 and 37 days. The admissions with a diagnosis of ADHD and other Conduct Disorders had the least number of admissions and the longest length of stay between 70-104 days.

- Gender. Males have the most admissions and a longer length of stay than females at 37.3 to 31.4 days.

- Age Group. The age groups 21-59 have the most admissions and the shortest length of stay of 30-35 days. The younger age groups (5-17) have a longer length of stay.